PRINTED: 05/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUR COMPLETE	
		15K072	B. WIN	G_			5/ 2012
	OVIDER OR SUPPLIER			5	REET ADDRESS, CITY, STATE, ZIP CODE 5410 W WASHINGTON ST NDIANAPOLIS, IN 46241	1 30,00	3.2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	3	G	000			
	This visit was for a fo						
		8937 - Substantiated- Federal o the allegations are cited.					
	Survey Date: March	5, 2012					
	Medicaid #; 2010283	360					
	Facility #: 012539						
	Surveyors: Linda Du Public Hea	bak, R.N. alth Nurse Surveyor					
		cker, R.N. alth Nurse Surveyor					
	Quality Review: Joyo March 9, 20	ce Elder, MSN, BSN, RN 012					
G 129	Census 0 484.14(b) GOVERNI	NG BODY	G	129			
	The governing body administrator.	appoints a qualified					
	Based on interview and Department of Health agency failed to ensuradministrator for 1 of	not met as evidenced by: and review of Indiana State n (ISDH)documentation, the ure there was an if 1 agency with the potential oning of the agency.					
	Findings include:						
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	15K072 B. WING			5/ 2012			
	OVIDER OR SUPPLIER		•	54	EET ADDRESS, CITY, STATE, ZIP CODE 110 W WASHINGTON ST IDIANAPOLIS, IN 46241		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 129	indicated the former a nursing resigned in C alternate director of nursing resigned in C alternate director of nursing resigned in C alternate director of nursing the promoted to the He indicated he had a employ a qualified perhad been in contact will the position. He had been in contact will the positions. 2. ISDH documentat was issued a full licer at 10:15 AM, Employ deliver notice of her mand Director of Nursing 484.14(c) ADMINIST A qualified person is at the absence of the action.	5 AM, the agency's owner administrator / director of administrator / director of administrator / director of administrator / director of administrator of nursing position. Attempted several times to a rson for this position. He with Job One in an attempt to ad not received much and net received much are. He was using word of the with a director of the agency are on 09/01/11. On 2/21/12 are B arrived at ISDH to hand designation as Administrator and of Alpha Care. RATOR authorized in writing to act in diministrator.	G	129	DEFICIENCY)		
	Based on interview a Department of Health agency failed to ensu	not met as evidenced by: and review of Indiana State I (ISDH)documentation, the re there was an alternate 1 agency with the potential oning of the agency.					
	agency indicated he	5 AM, the owner of the currently does not have or. He had been in contact					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K072	B. WIN	G			5/ 2012
	ROVIDER OR SUPPLIER			5410	T ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST IANAPOLIS, IN 46241	, 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 137	He had not received One. He was using otherwise actively s. The former administ resigned in October director of nursing, promoted to the number of nursing search of	attempt to fill the positions. If much feedback from Job word of mouth, but is not eeking to fill the positions. It attor / director of nursing 2011 and the alternate employee B, was then ector of nursing position. Attion evidenced the agency ense on 09/01/11. If the facility informed the arching for replacement of attor. At 10:15 AM, Employee B result of a request to call oned whether the agency had strator in place, she indicated er as the owner would have to ted the owner does all of the rolved in the decision making at 11:30 AM, Employee B of follow up to make sure remation marketing the position trator. She was informed that mation regarding Person B as dministrator. She indicated an individual by that name.	G	137			

			MPLETED			
		15K072	B. WING	G	- ₀₃	C / 05/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 5410 W WASHINGTON ST INDIANAPOLIS, IN 46241	•	700/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
G 137		e 3 she was unaware of and did ate administrator that was	G ·	137		
G 138	REGIS. NURSE The skilled nursing all furnished are under to of a physician or a repreferably has at least experience and is a purpose. This STANDARD is a possible of the skilled properties of the ski	st 1 year of nursing public health nurse).	G ·	138		
	Department of Health agency failed to ensurance for 1 of 1 age affect all the functioning. Findings include: 1. On 3-5-12 at 10:4 agency indicated he nursing (DON). The director of nursing rest the alternate director then promoted to the He had been in the hand when he got out	and review of Indiana State in (ISDH)documentation, the irre there was an director of ency with the potential to ing of the agency. 5 AM, the owner of the does not have a director of former administrator / signed in October 2011 and of nursing, employee B, was director of nursing position. ospital for the past 2 weeks he went to the agency and esignation had been faxed to				
	2. ISDH documentat was issued a full licer	ion evidenced the agency nse on 09/01/11.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SUF	ED
		15K072	B. WIN	G			5/ 2012
	ROVIDER OR SUPPLIER			54	EET ADDRESS, CITY, STATE, ZIP CODE 110 W WASHINGTON ST IDIANAPOLIS, IN 46241	00/0	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 138	from facility stating the Person A was appoin (DON) by the Board, reflect qualifications. 9/29/11 requested recept. B. On 2/21/12 a arrived at ISDH to ha	the ISDH received a letter e DON position was vacant. ted new Director of Nursing but the resume does NOT A letter sent to facility quired documents. t 10:15 AM, Employee B nd deliver notice of her istrator and DON of Alpha		138			
	Services furnished ar direction of a physicia preferably has at least experience and is a particle. This person, or similar available at all times. This STANDARD is a Based on interview a Department of Health agency failed to ensure	arly qualified alternate, is during operating hours. That met as evidenced by: and review of Indiana State (ISDH)documentation, the are there was an alternate of 1 of 1 agency with the					
	indicated did not have nursing. He has an a hired, but the employ	5 AM, the agency's owner e an alternate director of alternate director of nursing ee has not started working ad been in contact with Job					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER		•	5410	ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST ANAPOLIS, IN 46241	, 00/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 139	not received much fe was using word of more actively seeking to fill administrator / director. October 2011 and the nursing, employee B, director of nursing pobeen without an alter will be until the new horder will be u	fill these positions. He had edback from Job One. He buth, but is not otherwise the positions. The former or of nursing resigned in ealternate director of was then promoted to the sition. The agency had nate director of nursing and irre starts. It is a constant of the ching for replacement of Nursing. It 10:15 AM, Employee B sponse to a request to call. either the agency had an Nursing in place, she ot answer as the owner of the ching and is involved in the eagency. It 11:30 AM, Employee B hed that ISDH received Person B as the new ursing. She indicated she ividual by that name. The	G	139			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	COMPLET	(X3) DATE SURVEY COMPLETED	
	15K072 B. WING			C 05/2012			
	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CO 5410 W WASHINGTON ST INDIANAPOLIS, IN 46241	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 139		e 6 ot appoint the alternate at was sent in to ISDH.	G 13	39			